PRTF Billing Manual

Psychiatric Residential Treatment Facilities (PRTFs)

Providers must be enrolled as a Health First Colorado provider in order to:

- Treat a Health First Colorado member
- Submit claims for payment to the Health First Colorado

Psychiatric Residential Treatment Facilities (PRTFs) provide services to mentally ill children and adolescents by treating mental disabilities and restoring the member to his or her best possible functional level. PRTF services are provided under the direction of a physician. The member must be:

- Health First Colorado eligible
- Determined to need PRTF care by a licensed professional
- PRTFs complete a Level of Care Review and submit it to the referring agency for prior authorization
- Determined in need of mental health services by the referring agency

Providers should refer to the Code of Colorado Regulations**,** Program Rules (10 C.C.R. 2505-10), for specific information when providing psychiatric residential treatment.

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department of Health Care Policy and Financing (the Department). Requests may be sent to the fiscal agent, Hewlett Packard Enterprise (HPE), P.O. Box 30, Denver, CO 80202-0030. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit 5 claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
  - Note: Attachments may be submitted electronically
- Reconsideration claims

Paper claims do not require an NPI, but do require the Health First Colorado provider number. In addition, the UB-04 Certification document must be completed and attached to all claims

submitted on the paper UB-04. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com)
- Companion Guides for the 837P, 837I, or 837D EDI support section of the Department's website (edi-support)
- Web Portal User Guide (via within the portal)

The Health First Colorado collects electronic claim information interactively through the Health First Colorado Secure Web Portal (Web Portal) or via batch submission through a host system.

Interactive Claim Submission and Processing

Interactive claim submission through the Web Portal is a real-time exchange of information between the provider and the Health First Colorado. Health First Colorado providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time. These claims are transmitted through the Health First Colorado Online Transaction Processor (OLTP).

For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services Specifications section.

Batch Electronic Claims Submission

Batch billing refers to the electronic creation and transmission of several claims in a group. Batch billing systems usually extract information from an automated accounting or patient billing system to create a group of claim transactions. Claims may be transmitted from the provider's office or sent through a billing vendor or clearinghouse.

All batch claim submission software must be tested and approved by the Health First Colorado fiscal agent.

For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services Specifications section.

Prior Authorization Requirements

PRTF services must be provided and billed only by a licensed and certified PRTF provider. PRTFs complete a Level of Care Review and submit it to the referring agency for prior authorization. PRTFs are not required to submit any prior authorization documents to the fiscal agent HPE).

Paper Claim Reference Table

The information in the following table provides instructions for completing form locators (FL) as they appear on the paper UB-04 claim form. Instructions for completing the UB-04 claim form

are based on the current *National Uniform Billing Committee (NUBC) UB-04 Reference Manual.* Unless otherwise noted, all data form locators on the UB-04 have the same attributes (specifications) for the Health First Colorado as those indicated in the *NUBCUB-04 Reference Manual*.

All code values listed in the *NUBC UB-04 Reference Manual* for each form locator **may not** be used for submitting paper claims to the Health First Colorado. The appropriate code values listed in this manual must be used when billing the Health First Colorado.

The UB-04 Certification document (located after the Late Bill Override Date instructions and in the Provider Services Forms section) must be completed and attached to all claims submitted on the paper UB-04. Completed UB-04 paper Health First Colorado claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A of the Appendices in the Provider Services Billing Manuals section.

Do not submit "continuation" claims. Each claim form has a set number of billing lines available for completion. Do not crowd more lines on the form. Billing lines in excess of the designated number are not processed or acknowledged. Claims with more than one page may be submitted through the Web Portal.

The Paper Claim Reference Table below lists the required, optional and/or conditional form locators for submitting the paper UB-04 claim form to the Health First Colorado for PRTF services.

Form Locator and Label	Completion Format	Instructions
1. Billing Provider Name, Address, Telephone Number	Text	Required Enter the provider or agency name and complete mailing address of the provider who is billing for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
2. Pay-to Name, Address, City, State	Text	Required if different from FL 1. Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office box City State

Form Locator and Label	Completion Format	Instructions
		Zip Code Abbreviate the state using standard post office abbreviations.
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Optional Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
3b. Medical Record Number	17 digits	Optional Enter the number assigned to the member to assist in retrieval of medical records.
4. Type of Bill	3 digits	Required Enter the three-digit number indicating the specific type of bill following. For PRTF, use TOB 89X Digit 1 — Type of Facility 1 — Hospital 2 — Skilled Nursing 3 — Home Health Services 4 — Religious Non-Medical Health Care Institution 6 — Intermediate Care 7 — Clinic (Rural Health/FQHC/Dialysis Center) 8 — Special Facility (Hospice, RTCs)

4. Type of Bill (continued)	3 digits	Digit 2 Bill Classification (Except clinics & special facilities): 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Intermediate Care Level I 6 Intermediate Care Level II 7 Sub-Acute Inpatient (revenue code 19X required with this bill type) 8 Swing Beds 9 Other Digit 2 Bill Classification (Clinics Only): 1 Rural Health/FQHC 2 Hospital Based or Independent Renal Dialysis Center 3 Freestanding 4 **Outpatient** Rehabilitation Facility (ORF) **5** Comprehensive **Outpatient** Rehabilitation Facilities (COFRs) 6 Community Mental Health Center Digit 2 Bill Classification (Special Facilities Only): 1 Hospice (Non-Hospital Based) 2 Hospice (Hospital Based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 5 Critical Access Hospital 6 Residential Facility

Form Locator and Label	Completion Format	Instructions
4. Type of Bill (continued)	3 digits	Digit 3 / Frequency: 0 Non-Payment/Zero Claim 1 Admit through discharge claim 2 Interim - First claim 3 Interim - Continuous claim 4 Interim - Last claim 7 Replacement of prior claim 8 Void of prior claim
5. Federal Tax Number	None	Submitted information is not entered into the claim processing system.
6. Statement Covers Period – From/ Through	From: 6 digits MMDDYY Through: 6 digits MMDDYY	Required Each date of service must be billed on a separate line (see FL 45). On paper split an entire month into 2 claims. This form locator must reflect the beginning and ending dates of service. "From" date is the actual start date of services. "From" date cannot be prior to the start date reported on the initial prior authorization, if applicable, or is the first date of an interim bill. "Through" date is the actual discharge date, or final date of an interim bill. "From" and "Through" dates cannot exceed a calendar month (e.g., bill 01/15/09 thru 01/30/09 and 02/01/09 thru 02/15/09, not 01/15/09 thru 02/15/09). Match dates to the prior authorization if applicable. If member is admitted and discharged on the same date, the same date must appear in this FL. Detail dates of service must be within the "Statement Covers Period" dates.

Form Locator and Label	Completion Format	Instructions
8a. Patient Identifier		Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the member's last name, first name and middle initial.
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the member's street/post office box exactly as it appears on the eligibility verification or as determined at the time of admission.
9b. Patient Address – City	Text	Required Enter the member's city exactly as it appears on the eligibility verification or as determined at the time of admission.
9c. Patient Address – State	Text	Required Enter the member's state exactly as it appears on the eligibility verification or as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the member's zip code exactly as it appears on the eligibility verification or as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Optional
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the member's birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 07012007 for July 1, 2007. Use the birthdate that appears on the eligibility verification.
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the member's sex.

Form Locator and Label	Completion Format	Instructions
12. Admission Date	6 digits	Required Enter the date admitted to the PRTF
13. Admission Hour	6 digits	Not Required
14. Admission Type	1 digit	Required Enter the following to identify the admission priority: 3 - Elective The member's condition permits adequate time to schedule the availability of accommodations.
15. Source of Admission	1 digit	Required Enter the appropriate code. (To be used in conjunction with FL 19, Type of Admission). 8 Court/Law Enforcement 9 Information not available
16. Discharge Hour	2 digits	Not Required
17. Patient Discharge Status	2 digits	Required Valid Status Codes for PRTFs include 01 Discharged to Home or Self Care 5 Discharged to Another Type of Institution 6 Discharged to Home under Organized Home Health Care Program (HCBS) 7 Left Against Medical Advice 09 Admitted as an Inpatient to Hospital 20 Expired 30 Still Patient 31 Still Patient- Waiting Transfer to Long Term Psychiatric Hospital 32 Still Patient- Waiting Placement by Department of Social Services

Form Locator and Label	Completion Format	Instructions
		Claims with Member Status of 30, 31 or 32 will pay for each day billed on the detail lines, including the through date of service shown at the header. Claims with any other member status will **not** pay for the through date of service if it is billed on a detail line. When a member is discharged, the date of discharge is not covered.
18-28. Condition Codes	2 Digits	Not required
29. Accident State		Not required
31-34. Occurrence Code/Date	2 digits and 6 digits	Not Required
35-36. Occurrence Span Code From/ Through	2 digits and 6 digits	Not Required
38. Responsible Party Name/ Address	None	Leave blank

Form Locator and Label	Completion Format	Instructions
39-41. Value Code and Amount	2 characters and 9 digits	Conditional Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. Never enter negative amounts. If a value code is entered, a dollar amount or numeric value related to the code must always be entered. 01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible 14 No fault including auto/other 15 Worker's Compensation 31 Member Liability Amount 32 Multiple Member Ambulance Transport 37 Pints of Blood Furnished 38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO 45 Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 13 (Admission Hour). 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-Covered Days *Enter the deductible amount applied by indicated payer:* A1 Deductible Payer A B1 Deductible Payer B

Form Locator and Label	Completion Format	Instructions
		C1 Deductible Payer C

Form Locator and Label	Completion Format	Instructions
39-41. Value Code and Amount (continued)	2 characters and 9 digits	*Enter the amount applied to member's co-insurance by indicated payer:* A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C *Enter the amount paid by indicated payer:* A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C For Rancho Coma Score bill with appropriate diagnosis for head injury. Medicare & TPL - See A1-A3, B1-B3, & C1-C3 above.
42. Revenue Code	4 digits	Required Enter the revenue code 0911. A revenue code must appear only once per date of service. * If more than one of the same service is provided on the same day, combine the units and charges on one line accordingly.
43. Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description.
44. HCPCS/Rates / HIPPS Rate Codes	5 digits	Not required
45. Service Date	6 digits	For span bills only Enter the date of service using MMDDYY format for each detail line completed. Each date of service must fall within the date span entered in the "Statement Covers Period" field (FL 6).

Form Locator and Label	Completion Format	Instructions
46. Service Units	3 digits	Required Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit)
46. Service Units (continued)	3 digits	For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.
47. Total Charges	9 digits	Required Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.
48. Non-Covered Charges	9 digits	Required Enter incurred charges that are not payable by the Health First Colorado. Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges.) Each column requires a grand total.
50. Payer Name	Text	Required Enter the name of each payer organization from which the provider might expect payment. At least one line must be the Health First Colorado.
51. Health Plain ID	8 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the eight digit Health First Colorado provider number assigned to the **billing provider**. Payment is made to the enrolled provider or agency that is assigned this number.

Form Locator and Label	Completion Format	Instructions
52. Release of Information	None	Submitted information is not entered into the claim processing system.
53. Assignment of Benefits	None	Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Inpatient - Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.
55. Estimated Amount Due	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Health First Colorado after provider has received other third party, Medicare or member liability amounts on the Health First Colorado line. **Medicare Crossovers** Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and member liability amounts.
56. National Provider Identifier (NPI)	10 digits	Optional Enter the billing provider's 10-digitNational Provider Identifier (NPI).
57. Other Provider ID		Submitted information is not entered into the claim processing system.
58. Insured's Name	Up to 30 characters	Required Enter the member's name on the Health First Colorado line. **Other Insurance/Medicare** Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial exactly as it appears on the eligibility verification or on the health insurance card.

Form Locator and Label	Completion Format	Instructions
60. Insured's Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the eligibility verification or on the health insurance card. Include letter prefixes or suffixes.
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the PAR/authorization number in this field, if a PAR is required and has been approved for services.
64. Document Control Number		Conditional
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Submitted information is not entered into the claim processing system.

Form Locator and Label	Completion Format	Instructions
		Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)
67. Principal Diagnosis Code	Up to 6 digits	Required Enter the exact ICD-10-CM diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.
67A- 67Q. Other Diagnosis	6 digits	Optional Enter the exact ICD-10-CM diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.
69. Admitting Diagnosis Code	6 digits	Required Enter the ICD-10-CM diagnosis code as stated by the physician at the time of admission.
70. Patient Reason Diagnosis		Submitted information is not entered into the claim processing system.
71. PPS Code		
72. External Cause of Injury Code (E-code)	6 digits	Optional Enter the ICD-10-CM diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".
74. Principal Procedure Code/ Date	7 characters and 6 digits	**Conditional** Enter the ICD-10-CM procedure code for the principal procedure performed during this billing period and the date on which procedure was

Form Locator and Label	Completion Format	Instructions
		performed. Enter the date using MMDDYY format. Apply the following criteria to determine the principle procedure: The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment; and The principal procedure is most related to the primary diagnosis.
74A. Other Procedure Code/Date	7 characters and 6 digits	Conditional Complete when there are additional significant procedure codes. Enter the ICD-10-CM procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principle diagnosis. Enter the date using MMDDYY format.
76. Attending **NPI – Required** **Attending- Last/ First Name**	NPI - 10 digits	Health First Colorado ID Required NPI - Enter the 10-digit NPI number assigned to the physician having primary responsibility for the member's medical care and treatment. This number is obtained from the physician, and cannot be a clinic or group number. (If the attending physician is not enrolled in the Health First Colorado or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Hospitals may enter the member's regular physician's 10-digit NPI in the Attending Physician ID form locator if the locum tenens physician is not enrolled in the Health First Colorado. QUAL – Enter "1D " for Medicaid Enter the attending physician's last and first name.

Form Locator and Label	Completion Format	Instructions
		This form locator must be completed for all services.
77. Operating-NPI		Not required Submitted information is not entered into the claim processing system.
78-79. Other ID **NPI – Conditional**	NPI - 10 digits	Conditional – Complete when attending physician is not the PCP or to identify additional physicians. Ordering, Prescribing, or Referring NPI - when applicable NPI - Enter up to two 10-digit NPI numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the PCP or if a clinic is a PCP agent, enter the PCP NPI number as the referring physician. The name of the Health First Colorado member's PCP appears on the eligibility verification. Review either for eligibility and PCP. The Health First Colorado does not require that the PCP number appear more than once on each claim submitted. The attending physician's last and first name are optional.
80. Remarks	Text	Enter specific additional information necessary to process the claim or fulfill reporting requirements.
81. Code-Code-QUAL/CODE/VALUE (a-d)		Submitted information is not entered into the claim processing system.

Timely Filing

The Health First Colorado allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Health First Colorado providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services Billing Manuals section.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to a fine and imprisonment under state and/or federal law.

Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: **Date:**

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

Psychiatric Residential Treatment Facility Claim Example

Psychiatric Residential Treatment Facility
100 Saginaw Street
Anytown, CO 80201
303-333-3333

1111110060 | 892

10/1/2016 – 10/4/2016

Client, Ima D. | 123 Main Street | Anytown | CO | 88888

02/13/2000 | F | 10/01/2016 | 03 | 5 | 30

911	Psych/Rehab		10/1/16	1	100.00		
911	Psych/Rehab		10/2/16	1	100.00		
911	Psych/Rehab		10/3/16	1	100.00		
911	Psych/Rehab		10/4/16	1	100.00		
	PAGE 1 OF 1		CREATION DATE		TOTALS	400.00	

D-Medicaid | 1234567890

Client, Ima D. | A123456

F0390

F22

1234567890

PRTF Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016, please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on the Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*2, 4*	*HPE (now DXC)*
1/10/2017	*Updates based on the Colorado iC Stage II Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on the Colorado iC Stage II Provider Billing Manual Comment Log v0_4.xlsx*	*Multiple*	*HPE (now DXC)*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE (now DXC)*
3/13/2017	*Updated the Type of Bill section in the Paper Claims Table to reflect the NUBC manual*	*4*	*RC*
5/26/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*1*	*DXC*

Note: *In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above, are the page numbers on which the updates/changes occur.*